COMMONWEALTH OF KENTUCKY

SUMMARY PLAN DESCRIPTION

COMMONWEALTH OF KENTUCKY DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

The *Plan* Sponsor has established and continues to maintain this Commonwealth of Kentucky Dependent Care Flexible Spending Account (the "*Plan*") for the benefit of its *associates* and their eligible *dependents* as provided in this document.

Benefits under this *Plan* are provided on a self-insured basis, which means that payment for benefits is ultimately the sole financial responsibility of the *Plan* Sponsor. Certain administrative services with respect to the *Plan*, such as claims processing, are provided under a services agreement.

Any changes in the *Plan*, as presented in this *Summary Plan Description*, must be properly adopted by the *Plan* Sponsor, and material modifications must be timely disclosed in writing and included in or attached to this document. A verbal modification of the *Plan*, or promise having the same effect, made by any person will not be binding with respect to the *Plan*.

Louisville Plan Number: 236118

Lexington Plan Number: 236135

North Kentucky Plan Number: 236216

Effective Date: January 1, 2008

Plan Year: January 1, 2008 through December 31, 2008

Employer's Federal Tax Identification Number: 61-0600439

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PLAN INFORMATION

GENERAL INFORMATION ABOUT THE PLAN

The Commonwealth of Kentucky (the "*Employer*") has established the Commonwealth of Kentucky Dependent Care Flexible Spending Account (the "Plan"). The Plan allows you to use *Pre-tax Contributions* to pay for qualified expenses. This Plan helps you because the benefits you elect are nontaxable. The Commonwealth of Kentucky Dependent Care Flexible Spending Account contains two components:

(i) A Cafeteria Plan. The Cafeteria Plan allows you to pay your share of certain underlying welfare benefit plans (called "Benefit Plan Options") with *Pre-tax Contributions*.

(ii) The Dependent Care Spending Account ("Dependent Care FSA"). The Dependent Care FSA allows you to elect to use a specified amount of *Pre-tax Contributions* to be used for reimbursement of Employment Related Expenses. The Dependent Care FSA is intended to qualify as a *Code* Section 129 dependent care assistance plan.

Each of these components is summarized in this document. Each summary and the attached Appendices constitute the *Summary Plan Description* for the Commonwealth of Kentucky Dependent Care Flexible Spending Account. The *SPD* (collectively, the *Summary Plan Description* or "*SPD*") describes the basic features of the Plan(s), how they operate, and how you can get the maximum advantage from them. Certain words in this Summary are italicized. Italicized words reflect important terms that are specifically defined in Appendix III of this Summary. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under the Plan(s).

Participation in the Plan(s) does not give any *Participant* the right to be retained in the employ of his or her *Employer* or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan(s), you may also contact the *Plan Administrator*.

PLAN CONTACT INFORMATION

If you have any questions about the Commonwealth of Kentucky Dependent Care Flexible Spending Account, you should contact the Third Party Administrator or the *Plan Administrator*.

Employer / Plan Sponsor

Commonwealth of Kentucky
Personnel Cabinet, Department for Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
502-564-0350
502-564-0351

Plan Administrator

Commonwealth of Kentucky
Personnel Cabinet, Department for Employee Insurance
501 High Street
Second Floor
Frankfort, KY 40601
502-564-0350
502-564-0351

Third Party Administrator

Humana
Attn: Humana Spending Account Administration Team
PO Box 3967
Louisville KY 40201-3967
Toll Free: 1-800-604-6228
Fax: 1-800-905-1851

CAFETERIA PLAN SUMMARY

PARTICIPATION

You are eligible to participate in this Plan if you satisfy the below Eligibility Requirements. Those *employees* who actually participate in the Cafeteria Plan are called "*Participant*s."

"Employee" shall mean a person, including an elected public official, who is regularly employed by any department, board, agency, or branch of state government, and who is a contributing member to any one (1) of the retirement systems administered by the state.

Eligibility for coverage under any given Benefit Plan Option shall be determined not by this Plan but by the terms of that Benefit Plan Option. The terms of eligibility of this Cafeteria Plan do not override the terms of eligibility of each of the Benefit Plan Options. In other words, if you are eligible to participate in this Cafeteria Plan, it does not necessarily mean you are eligible to participate in the Benefit Plan Options.

You may be *required* to pay for any Benefit Plan Option coverage that you elect with *Pre-tax Contributions*. When you elect to participate both in a Benefit Plan Option and this Cafeteria Plan, an amount equal to your share of the annual cost of those Benefit Plan Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you have chosen to use *Pre-tax Contributions* (or it is a plan requirement), the deduction is made before any applicable federal and/or state taxes are withheld.

ENROLLMENT

The purpose of the Cafeteria Plan is to allow eligible *employees* to pay for certain benefit plans (Benefit Plan Options) with pre-tax dollars ("*Pre-tax Contributions*"). Each *employee* of the *Employer* (or an *Affiliated Employer*) who

(i) satisfies the Cafeteria Plan Eligibility Requirements and
(ii) is also eligible to participate in any of the Benefit Plan Options will be eligible to participate in this Cafeteria Plan.

If you have satisfied the Cafeteria Plan's eligibility requirements, you may become a *Participant*. You may enroll during the year if you previously elected not to participate and you experience a change described below that allows you to become a *participant* during the year. If that occurs, you must complete an election change form during the Election Change Period.

The Cafeteria Plan has three election periods:

(i) the “Initial Election Period,” (Upon Hire)
(ii) the “Annual Election Period,” (Open Enrollment) and
(iii) the “Election Change Period”, which is the period following the date you have a *Qualifying Event*.

The following is a summary of the Initial Election Period and the Annual Election Period.

The Initial Election Period

Upon satisfying the Dependent Care FSA Eligibility Requirements, you are eligible to enroll in the Commonwealth of Kentucky Dependent Care Flexible Spending Account. The election that you make during the Initial Election Period is effective for the remainder of the *Plan Year* and generally cannot be changed during the *Plan Year* unless you have a *Qualifying Event*.

The Annual Election Period

The Cafeteria Plan also has an "Annual Election Period" during which you may enroll if you did not enroll during the Initial Election Period or change your elections for the next *Plan Year*. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period. The election that you make during the Annual Election Period is effective the first day of the next *Plan Year* and cannot be changed during the entire *Plan Year* unless you have a *Qualifying Event* described below.

ELECTION CHANGES

If you experience a Qualifying Event as described in the Cafeteria Plan Summary and in the Qualifying Event Chart, you may make the permitted election changes described in the Qualifying Event Chart if you complete and submit an election change form within 30 days after the date of the event, unless the event is for birth of a newborn, or adoption or placement for adoption, in which you have 60 days from the date of birth, adoption, or placement for adoption to submit an election change form.

Generally, you cannot change your election under this Cafeteria Plan during the *Plan Year*. There are, however, a few exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Cafeteria Plan or under all of the Benefit Plan Options that you have chosen.

Second, you may voluntarily change your election during the *Plan Year* if you satisfy the following conditions (prescribed by federal law):

(i) You experience a *Qualifying Event* that affects your eligibility under this Cafeteria Plan and/or a Benefit Plan Option; and

(ii) You complete and submit a written Election Change Form within the Election Change period.

Qualifying Events recognized by this Cafeteria Plan, and the rules surrounding election changes in the event you experience a *Qualifying Event* are described in the Qualifying Event Chart attached to this *SPD*. If coverage under a Benefit Plan Option ends, the corresponding *Pre-tax Contributions* for that coverage will automatically end. No election is needed to stop the contributions.

LEAVE OF ABSENCE

The following is a general summary of the rules regarding participation in the Cafeteria Plan (and the Benefit Plan Options) during a leave of absence. The specific election changes that you can make under this Cafeteria Plan following a leave of absence are described in the Qualifying Event Chart.

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the *Employer* will continue to maintain your Benefit Plan Options that provide health coverage on the same terms and conditions as though you were still active to the extent required by FMLA .

(b) Your *Employer* may elect to continue all health coverage for *Participant*s while they are on paid leave (provided *Participant*s on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with *Pre-tax Contributions* if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave,

(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with *Pre-tax Contributions* from your pre-leave *compensation* by making a special election to that effect before the date such *compensation* would normally be made available to you. However, pre-payments of *Pre-tax Contributions* may not be utilized to fund coverage during the next *Plan Year*.

(iii) By other arrangements agreed upon between you and the *Plan Administrator* (for example, the *Plan Administrator* may fund coverage during the leave and withhold amounts from your *compensation* upon your return from leave).

The payment options provided by the *Employer* will be established in accordance with *Code* Section 125, FMLA and the *Employer*'s internal policies and procedures regarding leaves of absence and will be applied uniformly to all *Participant*s. Alternatively, the *Employer* may require all *Participant*s to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator. The Qualifying Event Chart will let you know whether you are able to drop your coverage or whether you are required to continue coverage during the leave.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Cafeteria Plan and the Benefit Plan Option upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Plan Options providing health coverage may be automatically reinstated provided that coverage for *Employees* on non-FMLA leave is automatically reinstated upon return from leave.

(e) The *Employer* may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the *Employer*.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Cafeteria Plan for Benefit Plan Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Plan Options are treated with respect to *Participant*s commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Cafeteria Plan or a Benefit Plan Option offered under this Cafeteria Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by *after-tax contributions* while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Cafeteria Plan or a Benefit Plan Option, the election change rules described herein will apply. The *Plan Administrator* will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Cafeteria Plan indefinitely, it has the right to modify or terminate the Cafeteria Plan at any time and for any reason.

Your coverage under the Cafeteria Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with this Cafeteria Plan Summary;
(ii) The date that you no longer satisfy the Eligibility Requirements of this Cafeteria Plan;
(iii) The date that you terminate employment with the *Employer*; or
(iv) The date that the Cafeteria Plan is either terminated or amended to exclude you or the class of *employees* of which you are a member.

If your employment with the *Employer* is terminated during the *Plan Year* or you otherwise cease to be eligible, your active participation in the Cafeteria Plan will <u>*automatically*</u> cease. You will not be able to make any more *Pre-tax Contributions* under the Cafeteria Plan.

If you are rehired within the same *Plan Year* and are eligible for the Cafeteria Plan (or you become eligible again), you may make new elections if you are rehired or become eligible again 30 days or more after you terminated employment or lost eligibility (subject to any limitations imposed by the Benefit Plan Option(s)). If you are rehired or again become eligible less than 30 days of your termination date, your Cafeteria Plan elections that were in effect when you terminated employment or stopped being eligible will be reinstated and remain in effect for the remainder of the *Plan Year* (unless you are allowed to change your election in accordance with the terms of the Plan).

TAX ADVANTAGES

You save both federal income tax and FICA (Social Security) taxes by participating in the Cafeteria Plan. Cafeteria Plan participation will reduce the amount of your taxable *compensation*. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable *compensation*.

DEPENDENT CARE ELIGIBILITY REQUIREMENTS

PARTICIPATION

Each *employee* who satisfies the Dependent Care FSA Eligibility Requirements is eligible to participate in the Dependent Care FSA on the Dependent Care FSA Eligibility Date.

"Employee" shall mean a person, including an elected public official, who is regularly employed by any department, board, agency, or branch of state government, and who is a contributing member to any one (1) of the retirement systems administered by the state.

If you have otherwise satisfied the Dependent Care FSA's Eligibility Requirements, you become a *participant* in the Dependent Care FSA by electing Dependent Care Reimbursement benefits during the Initial or Annual Election Periods. Your participation in the Dependent Care FSA will be effective on the date that you make the election or your Dependent Care FSA Eligibility Date, whichever is later. If you have made an election to participate and you want to participate during the next *Plan Year*, you must make an election during the Annual Election Period, even if you do not change your current election. Evergreen elections do not apply to Dependent Care FSA elections.

You may also become a *participant* if you experience a *Qualifying Event* that permits you to enroll mid year.

ENROLLMENT

If you elect to participate in the Dependent Care FSA, the *Employer* will establish a "Dependent Care Account" to keep a record of the reimbursements you are entitled to, as well as the contributions you elected to withhold for such benefits during the *Plan Year*. No actual account is established; it is merely a bookkeeping account. Benefits under the Dependent Care FSA are paid as needed from the *Employer*'s general assets.

During the enrollment period, you will specify the amount of Dependent Care Reimbursement you wish to pay for with *Pre-tax Contributions*. Thereafter, each paycheck will be reduced by an amount equal to a pro-rata share of the annual contribution.

The annual amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue *Code*. The minimum annual amount for the Commonwealth of Kentucky Dependent Care Flexible Spending Account is $120 per *Plan Year*. The maximum annual amount if you are –

• married and file a joint return	$5,000 per *Plan Year*
• married but your *Spouse* maintains a separate residence for the last 6 months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA	$2,500 per *Plan Year*
• single head of household	$5,000 per *Plan Year*

If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive on a tax free basis during the *Plan Year* cannot exceed the lesser of your earned income (as defined in *Code* Section 32) or your *spouse*'s earned income.

Your *Spouse* will be deemed to have earned income of $250 if you have one Qualifying Individual and $500 if you have two or more Qualifying Individuals (described below), for each month in which your *Spouse* is

(i) physically or mentally incapable of caring for himself or herself, or
(ii) a full-time *student* (as defined by *Code* Section 21).

TAX ADVANTAGES

You will not normally be taxed on your Dependent Care Reimbursement so long as your family's aggregate Dependent Care Reimbursement (under this Dependent Care FSA) does not exceed the maximum annual reimbursement limits described above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Employment Related Expenses may be eligible for the dependent care credit.

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax *Code*. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1,050 for one Qualifying Individual or $2,100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

ELECTION CHANGES

You can change your election under the Dependent Care FSA in the following situations:

(i) For any reason during the Annual Election Period. You can change your election during the Annual Election Period for any reason. The election change will be effective the first day of the *Plan Year* following the end of the Annual Election Period.

(ii) Following a *Qualifying Event*. You may change your Dependent Care FSA election <u>during</u> the *Plan Year* only if you experience a *Qualifying Event*.

Qualifying events are governed by 26 C.F.R. § 1.125-4.

LEAVE OF ABSENCE

Refer to the Cafeteria Plan Summary and the Qualifying Event Chart to determine what, if any, specific changes you can make during a leave of absence.

TERMINATION OF COVERAGE

Although the *Employer* expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason.

Your coverage under the Dependent Care FSA ends on the earlier of the following to occur:

(i) the date that you elect not to participate in accordance with the Cafeteria Plan Summary;
(ii) the last day of the *Plan Year* unless you make an election during the Annual Election Period;
(iii) the date that you no longer satisfy the Dependent Care FSA Eligibility Requirements;
(iv) the date that you terminate employment; or
(v) the date that the Plan is terminated or you or the class of eligible *employees* of which you are a member are specifically excluded from the Plan.

If you terminate employment or you cease to be eligible during the *Plan Year*, you may submit for reimbursement Eligible Employment Related Expenses incurred prior to your termination date up to the amount of your Dependent Care Account.

DEPENDENT CARE REIMBURSEMENT

ELIGIBLE CLAIMS EXPENSE

Eligible Expenses must be incurred ***during*** the *Plan Year*. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective or for any expenses incurred after the termination date.

You may be reimbursed for dependent care expenses ("Eligible Expenses"). Generally, an expense must meet <u>all</u> of the following conditions for it to be an Eligible Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A Qualifying Individual is:

   (i) An individual age 12 or under who
   (a) has the same principal place of abode as you,
   (b) does not provide over half of his/her own support and
   (c) is your “child” (son, daughter, grandchildren, step children, brother, sister, niece and nephew).

   Note: There is a special rule for children of divorced parents. If you are divorced, the child is a qualifying individual with respect to you if the child lives with you even if you have permitted the non-custodial parent to take the exemption; <u>or</u>

   (ii) a *Spouse* or other tax Dependent (as defined in *Code* Section 152) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. NOTE: Effective January 1, 2005, there is an income limitation, in addition to a support requirement (and a residence requirement for certain non-relatives) for all individuals (other than a *spouse*) age 19 and older (or between age 19 and 23 if a full-time *student*) under *Code* Section 152. Generally, such an individual cannot qualify as a *Code* Section 152 dependent if he/she has gross income in excess of the exemption amount under *Code* Section 151

3. The expense is incurred for the <u>care</u> of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your *Spouse*, if applicable) to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

   The expense is not paid or payable to a “child” (as defined in *Code* Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your *Spouse* is entitled to a personal tax exemption as a Dependent.

6. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

   You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

“Qualifying Dependent Care Services" means the following: Services that both (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCAP Component and during the Period of Coverage; and (2) are performed— in the Participant's home; or outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility and that receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

CLAIMS REIMBURSEMENT

Under this Dependent Care FSA, you can complete and submit a written claim for reimbursement.

Traditional Paper Claims

When you incur an Eligible Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. Forms can be mailed to PO Box 3967, Louisville, KY 40201 or faxed to 1-800-905-1851. You may obtain a Request for Reimbursement Form from the *Plan Administrator* or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g., a bill from the day care provider.) associated with each expense that indicates the following:

(i) The nature of the expense;
(ii) The date the expense was incurred; and
(iii) The amount of the expense.

The Third Party Administrator will process the claim once it receives the Request for Reimbursement Form from you. You must submit all claims for reimbursement for Eligible Expenses during the *Plan Year* in which they were incurred or during the Run Out Period.

The Run Out Period is the period during which expenses incurred during a *Plan Year* must be submitted to be eligible for reimbursement. The Run Out Period for active and terminated employees ends ninety days after the end of the Plan Year.

DENIED CLAIM

If your claim for benefits is denied, you will have the right to a full and fair review process. You should refer to Appendix I for a detailed summary of the Claims Procedures under this Plan.

UNCLAIMED DEPENDENT CARE REIMBURSEMENTS

Any Dependent Care Reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the *Plan Year* following the *Plan Year* in which the Eligible Expense was incurred shall be forfeited.

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Expenses you have incurred and the annual Dependent Care Reimbursement you have elected and paid for. Any amount credited to a Dependent Care Account shall be forfeited by the *Participant* and restored to the *Employer* if it has not been applied to provide the elected reimbursement for any *Plan Year* by the end of the Run Out Period following the end of the *Plan Year* for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs or as otherwise permitted under applicable law.

APPENDIX I

CLAIMS REVIEW PROCEDURE CHART

The *Effective Date* of this Appendix I is January 1, 2008. It should replace and supersede any other Appendix I with an earlier date. The Plan has established the following claims review procedure in the event you are denied a benefit under this Plan.

Step 1: Notice is received from Third Party Administrator. If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Review your notice carefully. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

a. the reason(s) for the denial and the Plan provisions on which the denial is based;
b. a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
c. a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d. a right to request all documentation relevant to your claim.

Step 3: If you disagree with the decision, file an Appeal. If you do not agree with the decision of the Third Party Administrator and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: Notice of Denial is received from Third Party Administrator. If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: Review your notice carefully. You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator. If you still do not agree with the Third Party Administrator's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

APPENDIX II

QUALIFYING EVENT CHART

Note: Shaded columns do **NOT** apply to this Summary Plan Description.

Event	**Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents**	**Commonwealth Choice Dependent Care FSA**
Change in Employee's Legal Martial Status		
Marriage (Gain Spouse)	Employee may enroll or increase election *or* --------------------------------------- Employee may decrease employee election if family members become covered under spouse's health plan (2)	Employee may enroll or increase election if marriage increases dependent care expenses (3) *or* --- Employee may terminate or decrease election if family elects dependent care assistance under spouse's plan or marriage decreases dependent care expenses (3)
Divorce, legal separation, annulment (Lose Spouse)	Employee may enroll or increase election if event causes loss of coverage under spouse's health plan (2) *or* -- Employee may decrease employee election	Employee may enroll or increase election if event increases dependent care expenses (3) or causes loss of coverage under spouse's plan or Employee may terminate or decrease election if event decreases dependent care expenses
Spouse's death	Employee may enroll or increase election if death causes loss of coverage under spouse's health plan (2) *or* -- Employee may decrease employee election	Employee may enroll or increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses (3) *or* Employee may terminate or decrease election if death decreases dependent care expenses (3)
Change in Number of Employee's Dependents		

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Number of employee's eligible dependents increases by the following: **birth;** **adoption (10);** **or placement for adoption (10)**	Employee may enroll or increase election	Employee may enroll or increase election if employee has greater dependent care expenses
Number of employee's eligible dependents decreases (e.g., by death or because child becomes ineligible)	Employee may decrease employee election	Employee may terminate or decrease election if employee has reduced dependent care expenses
Change in Employee's Employment Status		
Employee terminates employment	Cease employee contributions; COBRA rules may apply	Cease employee contributions; COBRA rules do not apply
Employee is rehired less than 30- days after termination of employment.	Employee may reinstate prior election unless another event has occurred that allows a change (9) If employee did not elect COBRA during termination period, reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice): *Proration:* Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period *or* *Reinstatement:* Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	Employee may reinstate prior election unless another event has occurred that allows a change (9)
Employee is rehired 30 days or more after termination of employment	Employee may make election to same extent permitted as new employee	Employee may make election to same extent permitted as new employee
Employee commences official leave without pay	Employee contributions cease in accordance with Plan rules; COBRA rules may apply	Employee contributions cease; COBRA rules do not apply

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee returns from official leave without pay	Reinstate prior election unless another event has occurred that allows a change (9) Reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice): *(1) Proration:* Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period *or* *(2) Reinstatement:* Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	Reinstate prior election. Employee may continue to file dependent care claims for the remaining funds in account until the end of the plan year, in accordance with IRS rules *or* Change election if event changes dependent care expenses (3)
Employee returns from unpaid FMLA	Employee may continue contributions. If contributions ceased during FMLA, employee must be able to reinstate prior elections and may choose one of the following: (1) Proration: Employee may elect to continue at the same monthly contribution as prior to the FMLA and the annual amount is reduced by the contributions missed during the FMLA *or* (2) Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during FMLA.	Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee begins unpaid FMLA (4)	Elections continue for up to 12 weeks or until employment terminates or until employee begins official leave without pay, whichever comes first. Employees must select one of the following options: Employee may terminate elections *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	Decrease election if leave causes a decrease in dependent care expenses (3) *or* Employee may terminate elections *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee begins unpaid Military Leave	Employee may cease employee contributions *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	Employee may cease employee contributions *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment
Employee returns from unpaid Military Leave ***** Employees returning from Military Leave are eligible for coverage immediately upon return or may delay the effective date until military coverage ends.	Employee must be able to reinstate prior coverage and can choose one of the following: (1) Proration: Employee may elect to continue at the same monthly contribution as prior to the leave and the annual amount is reduced by the contributions missed during the leave *or* (2) Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during leave	Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee commences paid leave (assuming event does not affect eligibility for coverage)	No change allowed	Employee may decrease election if event decreases dependent care expenses (3)
Employee returns from paid leave	No change allowed	Employee may increase election if event increases dependent care expenses (3)
Employee changes worksite	No change allowed	Employee may decrease election if event decreases dependent care expenses (3) (10) *or* Employee may increase election if event increases dependent care expenses (3) (10) (unless the care provider is a relative)
Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan	Coverage/contributions cease in accordance with Plan rules; COBRA rules may apply	Employee contributions cease; COBRA rules do not apply
Other change in employee's employment status (e.g., switch from hourly to salaried status) that causes employee to become eligible for coverage under plan	Employee may make elections as if a new employee unless there was less than 30-day break in eligibility	Employee may make elections as if a new employee unless there was less than 30-day break in eligibility
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements.)		
Spouse or dependent terminates employment (or other change in employment status resulting in a loss of eligibility under the spouse or dependent's plan)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Employee may start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Employee may terminate or decrease election if event decreases dependent care expenses (3)

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Spouse or dependent commences employment (or other change in employment status triggering eligibility under the spouse or dependent's plan)	Employee may decrease or cease election if family becomes covered under health plan of spouse or dependent (2)	(Employee may start or increase election if event increases dependent care expenses (3) *or* Employee may terminate or decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent is out of work due to strike or lockout	Employee may start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Employee may start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Stop or decrease election if event decreases dependent care expenses (3)
Spouse or dependent returns to work following cessation of strike or lockout	Employee may decrease election if family becomes covered under health plan of spouse or dependent (2)	Employee may start or increase election if event increases dependent care expenses (3) *or* Stop or decrease election if family becomes covered under spouse's dependent care assistance plan
Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Employee may terminate or decrease election if event decreases dependent care expenses (3)

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Spouse or dependent returns from unpaid leave	Employee may decrease election if family becomes covered under spouse's or dependent's health plan (2)	Employee may start or increase election if event increases dependent care expenses (3) *or* Employee may terminate or decrease election if family becomes covered under spouse's dependent care assistance plan
Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be eligible for coverage under spouse's or dependent's plan (e.g., switch from salaried to hourly status)	Employee may enroll or increase election (2)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's plan (3)
Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (e.g., switch from hourly to salaried status)	Employee may decrease election if family members become covered under health plan of spouse or dependent (2)	Employee may decrease election *or* Employee may increase election if event increases dependent care expenses (3)
Change in Dependent Eligibility		
Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance	Employee may decrease election	Employee may terminate or decrease election if event decreases dependent care expenses (3) (10)
Unmarried dependent re-establishes plan eligibility requirement under applicable plan	Employee may enroll or increase election (5)	Employee may enroll or increase election if event increases dependent care expenses (3) (10)
Change in Residence		
Employee or spouse changes primary (6) residence and becomes ineligible for current benefit elections	No change allowed	Employee may make a corresponding election change if the child care provider changes (10)

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Other Events		
Loss of other group health insurance coverage that entitles employee or family member to be enrolled under HIPAA Special Enrollment Rights	Employee may enroll or increase election or Employee may enroll or increase election	No change allowed
Judgment, decree, or administrative order relating to health coverage for child	Employee may enroll or increase election if order requires employee to provide child's health coverage *or* -- Employee may decrease election if other parent covers child under order	No change allowed
Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare (Part A or Part B) or Medicaid	Employee may decrease election	No Change allowed
Employee, spouse, or dependent loses entitlement to Medicare (Part A or Part B), Medicaid, KCHIP, any governmental group health insurance coverage	Employee may enroll or increase election	No change allowed
Coverage or Cost Changes (8)		
Change in Cost		
Benefit Option has significant increase or decrease in cost	Does not apply No change allowed	Employee may make a corresponding change (increase or decrease). Increasing the election for a day care provider raising rates mid-year is only permitted if the provider is not a relative of the employee
Change In Coverage Under Another Employer Plan		
Employee's spouse makes elections during an open enrollment period that differs from the open enrollment period of the employer (7)	*After Open Enrolment and before January 1:* Employee may make corresponding Change *After 12/31* – No change allowed	Employee may make election change that "corresponds" with election change under the other employer plan

Event	Commonwealth Choice Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Commonwealth Choice Dependent Care FSA
Employee makes elections during an open enrollment period of another employer that differs from the open enrollment period of the employer (7)	*After Open Enrolment and before January 1:* Employee may make corresponding change *After 12/31* – No change allowed	Employee may make election change that "corresponds" with the change made with the other employer's plan
Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer	No change allowed	No change allowed
Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)	No change allowed	Employee may make election change that "corresponds" with the event

Permitted Election Changes

End Notes:

(1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called “tag-along” rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the “tag-along” rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the “tag-along” rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the “tag-along” rule.

(2) It appears this rule does not require that a spouse’s coverage include a Health FSA.

(3) By an increase or decrease in dependent care expenses, we mean that the event increases or decreases the amount of expenses that an employee can have reimbursed on a tax-free basis under Code section 129 from a dependent care assistance plan. For example, if the employee gets married and his or her spouse does not work outside the home, the spouse would be available to care for a child, and thus the employee may not be able to claim that dependent care expenses are being used to enable the employee to be gainfully employed — a condition that must be satisfied for the expense to be reimbursed on a tax-free basis under Code section 129. Conversely, the marriage can increase the amount of expenses reimbursable under the dependent care assistance plan if, for example, a new spouse or stepchild is a “qualifying individual” for whom dependent care assistance can be received. A spouse’s death or divorce might lead to fewer dependent care expenses eligible for reimbursement under section 129 if, for example, the spouse was a “qualifying individual.” Conversely, if the spouse was not employed outside the home, the death or divorce might require the employee to pay for a caregiver in order to remain gainfully employed, and therefore the expenses may be reimbursed on a tax-free basis under section 129.

(4) Most employees are entitled to certain rights under the Family and Medical Leave Act (FMLA), whether or not the benefits are provided through a cafeteria plan. Employees generally must receive up to 12 weeks of unpaid FMLA leave, although the employee or employer generally can choose to substitute available paid leave for unpaid leave. During FMLA leave, the employer must maintain group health coverage (including FSA coverage) on the same conditions as coverage would be provided if the employee had not taken the leave. An employee's entitlement to other benefits during FMLA leave is determined by the employer's established policy for providing such benefits when the employee is on other forms of paid or unpaid leave (as appropriate). If benefits are continued during unpaid leave, proposed IRS regulations allow benefits purchased through a cafeteria plan to be paid in several ways, including increased salary reductions before the leave to prepay benefits or using salary reductions after the leave to "catch-up" on payments. Benefits continued on paid FMLA leave are paid for in the same manner as during any paid leave. Employees can choose to drop benefits while on leave, but FMLA requires they have the right to be reinstated upon return from leave.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent.

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage, which does not include Veteran's Administration benefits, is considered "Another Employer Plan".

(8) "Cost or Coverage Changes under the Employer's Plan" are not included in this chart. In the event there is a mid-year change in the health plan, specific direction will be provided to the group or groups affected.

(9) An employee must request the mid-year election change within 30 days of the return to work date.

(10) Supporting documentation required.

(11) HIPAA Special Enrollment Right

(12) Qualifying Event permits change in plan option (Essential, Enhanced, Select or Premier).

APPENDIX II (continued)

Efective Dates

Effective dates for the various mid-year election changes are as follows:

Health Insurance

A. Events increasing coverage

1. Birth, adoption, placement for adoption = date of the event.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day of the 1st month from the employee's signature date.
3. Different Open Enrollment = 1st day of the 1st month (match effective date of other employer's plan).

B. Events decreasing coverage

1. Termination of employment = Last day of the month following the month in which employment ends.
2. Death = Date of death.
   a) Death of the employee with dependents = End of month in which death occurred.
   b) Death of employee no dependents = Date of death.
   c) Death of dependent = Date of death.
3. Divorce, loss of dependent status = End of the month of loss of eligibility.
4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
5. Different Open Enrollment = Last day of the month (match other employer's plan).

Healthcare Flexible Spending Account (HC FSA)

A. Events starting or increasing HC FSA contributions

1. Birth, adoption, placement for adoption = 1st day of the 1st month from the employee's signature date.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day of 1st month from the employee signature date.
3. Different open enrollment = 1st day of the 1st month (match effective date of other employer's plan).
4. Return from Leave Without Pay = 1st day of the 1st month from the employee's signature date.
5. Return from Military Leave = Date of return to work.

B. Events stopping or decreasing HC FSA contributions

1. Termination of employment = Date of termination of employment.
2. Death = Date of death.
3. Divorce, loss of dependent status = End of the month of loss of eligibility.
4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee’s signature date.
5. Different open enrollment = Last day of the month (match other employer’s plan).
6. Begins Leave without Pay or Military Leave = Last date of work.

Dependent Care Flexible Spending Account (DC FSA)

A. Events starting or increasing DC FSA contributions

1. Dependent is newly eligible to begin attending day care = 1st day of 1st month from the employee’s signature date.
2. Change in dependent’s eligibility status = 1st day of 1st month from the employee’s signature date.

B. Events stopping or decreasing DC FSA contributions

1. Termination of employment = Date of termination of employment.
2. Dependent no longer attends day care = End of the month from the employee’s signature date.
3. Change in dependent’s eligibility status = End of the month from the employee’s signature date.
4. Death = Date of death.

Health Reimbursement Account (HRA)

A. Events allowing enrollment in a Health Plan

1. Birth, Adoption, placement for adoption = Date of the event.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s), expiration of COBRA = 1st day of the 1st month from the employee signature date.
3. Different open enrollment = 1st day of the 1st month (match effective date of other employer’s plan).
4. Returning from Military Leave = Date of return to work or day after TRICARE ends (employee’s option).

B. Events allowing contributions to cease (for reasons other than enrolling in the plan).

1. Termination of employment = Date of termination of employment.
2. Death = Date of death.
3. Different open enrollment = Last day of the month (match other employer's plan).
4. Start Military Leave = Date of the event.

All Qualifying Events must be signed by the employee 30-days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which are 60-days. Qualifying Events dealing with loss of other group coverage or gaining other group coverage may be signed by the employee prior to the Qualifying Event date. In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place.

APPENDIX III

DEFINITIONS

Affiliated Employer - means any entity who is considered with the Employer to be a single employer in accordance with Code Section 414(b), (c), or (m).

After-tax Contribution(s) - means amounts withheld from an Employee's Compensation after all applicable state and federal taxes have been deducted. Such amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan.

Benefit Plan Option- means those Qualified Benefits available to a Participant under this Plan as amended and/or restated from time to time.

Code - means the Internal Revenue Code of 1986, as amended.

Compensation - means the cash wages or salary paid to an Employee by the Employer.

Effective Date - This is the date the Plan was established**.**

Employee - means an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include any of the following: (a) any leased employee (including, but not limited to, those individuals defined in Code § 414(n)); (b) an individual classified by the Employer as a contract worker or independent contractor; (c) an individual classified by the Employer as a temporary employee or casual employee, whether or not any such persons are on the Employer's W-2 payroll; and (d) any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement, except as otherwise provided for in the collective bargaining agreement.

Employer - means the Commonwealth of Kentucky and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Employer. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

Highly Compensated Individual - means an individual defined under Code Section 125(e), as amended, as a "highly compensated individual" or a "highly compensated employee."

Key Employee - means an individual who is a "key employee" as defined in Code Section 125(b)(2), as amended.

Participant - means an Employee who becomes a Participant pursuant to this Summary Plan Description.

Plan - means this Cafeteria Plan, as set forth herein.

APPENDIX III (continued)

Plan Administrator - means the person(s) or Committee identified in the Summary Plan Description that is appointed by the Employer with authority, discretion, and responsibility to manage and direct the operation and administration of the Plan. If no such person is named, the Plan Administrator shall be the Employer.

Plan Year - shall be the period of coverage set forth in this Summary Plan Description.

Pre-tax Contribution(s) - means amounts withheld from an Employee's Compensation before any applicable state and federal taxes have been deducted. The amounts are withheld for purposes of purchasing one or more of the Benefit Plan Options available under the Plan. This amount shall not exceed the premiums or contributions attributable to the most costly Benefit Plan Options' afforded hereunder, and for purposes of Code Section 125, shall be treated as an Employer contribution (this amount may, however, be treated as an Employee contribution for purposes of state insurance laws).

Qualifying Event - means any of the events described in this Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year.

Spouse - means an individual who is legally married to a Participant (and who is treated as a spouse under the Code).

Summary Plan Description or "SPD" - means the Flexible Benefits Plan SPD and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and as amended from time to time. The SPD and appendices are incorporated hereto by reference.

APPENDIX IV

NOTICE OF PRIVACY PRACTICES (SUMMARY)

THIS NOTICE DESRCIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice describes the obligations of the Department for Employee Insurance (DEI) and your legal rights regarding your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. This is a summary of DEI's Notice of Privacy Practices. For a complete Notice, please go to our web site at www.kehp.ky.gov or call our Member Services Branch at 888-581-8834.

The Kentucky Employees Health Plan (KEHP) is a self-funded governmental plan and, therefore, we are required to provide this Notice of Privacy Practice to you pursuant to HIPAA. DEI is the plan sponsor.

The HIPAA Privacy Rule protects only PHI. Generally, PHI is individually identifiable health information, including demographics information, collected from you or created or received by a health care provider, health care clearing house, or your employer on behalf of a group health plan that relates to: 1) your past, present, or future physical or mental health or condition; 2) the provisions or health care to you; or 3) past, present, or future payment for provisions of health care to you. DEI does not maintain information regarding your specific medical condition but does maintain PHI related to demographic information and other information that is necessary for determining eligibility and enrollment in the KEHP. If you have any questions about this Notice or about our Privacy Practices, please visit http://personnel.ky.gov/benefits/dei/hipaa.htm or contact Department for Employee Insurance, Attn; HIPAA Privacy Officer, 501 High Street, 2nd Floor, Frankfort, Kentucky 40601. The effective date of this Notice is January 1, 2008.

DEI Responsibilities

We are required by law to: 1) maintain the privacy of your PHI; 2) provide you with certain rights with respect to your PHI; 3) provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and 4) follow the terms of the Notice that is currently in effect. We reserve the right to change the terms of Notice and to make new provisions regarding your PHI that we maintain, or as required by law.

APPENDIX IV (continued)

How DEI May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your PHI under certain circumstance without your permission. The following categories represent the different ways that we may use or disclose your protected health information: 1) For Treatment; 2) For Payment; 3) For Health Care Operations; 4) To Business Associates; 5) As Required by.